	FOR	OHF	USE		

LLT

2000 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2000)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0027540			II. CERT	IFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: Manorcare at Oak Lawn/95th			l ha	ve examined the contents of the accompanying report to the
	Address: 16300 W. 95th St. Oak Lawn Number City		60453 Zip Code	State of	of Illinois, for the period from 06/01/99 to 05/31/00 ertify to the best of my knowledge and belief that the said contents
	County: Cook		•	are tru	e, accurate and complete statements in accordance with able instructions. Declaration of preparer (other than provider)
	Telephone Number: (708)599-8800 Fax # (708)599-8820				ed on all information of which preparer has any knowledge.
	IDPA ID Number: 520886946015				ntional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners: '11/01/81			Officer or	(Signed) (Date)
	Type of Ownership:			Administrator of Provider	(Type or Print Name) Barry Lazarus
	VOLUNTARY, NON-PROFIT X PROPRIETARY	GO	VERNMENTAL	oi Frovider	(Title) V.P., Director of Reimbursement
	Charitable Corp. Individual		State		
	Trust Partnership		County Other		(Signed)
	IRS Exemption Code X Corporation "Sub-S" Corp.			Paid	(Date) (Print Name
	Limited Liability	Co.		Preparer	and Title)
	Trust Other				(Firm Name
			_		& Address)
					(Telephone) () Fax # ()
	In the event there are further questions about this report, please contact:				MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID
	Name Gary Geise Telephone Number: (419)	252-5731			201 S. Grand Avenue East Springfield, 1L 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99) IL478-2471

STATE OF ILLINOIS Page 2 Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/99 Ending: 05/31/00 III. STATISTICAL DATA D. How many bed-hold days during this year were paid by Public Aid? A. Licensure/certification level(s) of care; enter number of beds/bed days, (Do not include bed-hold days in Section B.) (must agree with license). Date of change in licensed beds E. List all services provided by your facility for non-patients. 2 3 (E.g., day care, "meals on wheels", outpatient therapy) N/A Beds at Licensed Beginning of Licensure **Beds at End of Bed Days During** F. Does the facility maintain a daily midnight census? Yes Report Period Level of Care Report Period | Report Period G. Do pages 3 & 4 include expenses for services or 195 Skilled (SNF) 195 71,370 1 investments not directly related to patient care? Skilled Pediatric (SNF/PED) 2 YES NO 3 3 Intermediate (ICF) 4 4 H. Does the BALANCE SHEET (page 17) reflect any non-care assets? Intermediate/DD 5 5 **Sheltered Care (SC)** YES NO 6 ICF/DD 16 or Less 6 I. On what date did you start providing long term care at this location? 195 7 **TOTALS** 195 71,370 7 Date started 11/01/81 J. Was the facility purchased or leased after January 1, 1978? B. Census-For the entire report period. X Date 11/01/81 NO Level of Care Patient Days by Level of Care and Primary Source of Payment K. Was the facility certified for Medicare during the reporting year? Public Aid YES NO If YES, enter number and days of care provided Recipient Private Pay Other Total of beds certified **71** 7875 8 SNF 3,817 13,659 18,624 1,148 8 9 SNF/PED Medicare Intermediary Blue Cross of Maryland 10 ICF 8,704 27,400 10 4,308 40,412 11 ICF/DD 11 IV. ACCOUNTING BASIS 12 SC 12 **MODIFIED 13 DD 16 OR LESS** 13 ACCRUAL X CASH* 14 TOTALS 12,521 28,548 17,967 59,036 Is your fiscal year identical to your tax year? YES

Tax Year:

12/31/00

Fiscal Year: 05/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

bed days on line 7, column 4

C. Percent Occupancy. (Column 5, line 14 divided by total licensed

82.72%

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

LICA	BLE SECTION TO ZERO DE	CINAL PLA	ICES.		STATE OF II	LINOIS					Page 3	
	Facility Name & ID Number	Manorcare at	Ook Lown/0		#		Danart Paria	d Beginning:	06/01/99	Ending:	05/31/00	
	V. COST CENTER EXPENSES						Report 1 erio	u beginning.	00/01/77	Enumg.	03/31/00	•
	V. COST CENTER EXTENSES	(tiii ougiiout ti	Costs Per Ge			Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	USE ONLY	-
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	TOK OIII	USE OILLI	1
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	332,553	29,371	13,926	375,850	1,739	377,589	, 0	377,589		10	1
2	Food Purchase	002,000	230,219	10,>20	230,219	1,,0)	230,219	(160)	230,059			2
3	Housekeeping	166,662	21,293	2,122	190,077		190,077	0	190,077			3
4	Laundry	56,641	14,141	597	71,379		71,379	0	71,379			4
5	Heat and Other Utilities		,	179,096	179,096	20,655	199,751	0	199,751			5
6	Maintenance	64,140	16,629	74,034	154,803		154,803	0	154,803			6
7	Other (specify): Medical Waste			450	450		450	0	450			7
8	TOTAL General Services	619,996	311,653	270,225	1,201,874	22,394	1,224,268	(160)	1,224,108			8
	B. Health Care and Programs											
9	Medical Director			24,686	24,686		24,686	0	24,686			9
10	Nursing and Medical Records	2,651,091	340,794	91,732	3,083,617	27,963	3,111,580	0	3,111,580			10
10a	Therapy	452,573	8,218	123,027	583,818		583,818	0	583,818			10a
11	Activities	91,385	422	6,355	98,162		98,162	0	98,162			11
12	Social Services	130,945	564	71	131,580		131,580	0	131,580			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	3,325,994	349,998	245,871	3,921,863	27,963	3,949,826		3,949,826			16
	C. General Administration											
17	Administrative	105,131		526,000	631,131	(165,945)	465,186	0	465,186			17
18	Directors Fees							0				18
19	Professional Services			14,106	14,106	(14,106)		0				19
20	Dues, Fees, Subscriptions & Prome	otions		55,764	55,764		55,764	(20,631)	35,133			20
21	Clerical & General Office Expense		34,604	499,168	807,127	14,106	821,233	(396,241)	424,992			21
22	Employee Benefits & Payroll Taxe	Ð:		670,602	670,602	2,328	672,930	0	672,930			22
23	Inservice Training & Education			1,782	1,782		1,782	0	1,782			23
24	Travel and Seminar			9,538	9,538		9,538	0	9,538			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			162,947	162,947		162,947	0	162,947			26
27	Other (specify): Personal Purchas	ses		2,417	2,417		2,417	(2,417)				27
28	TOTAL General Administration	378,486	34,604	1,942,324	2,355,414	(163,617)	2,191,797	(419,289)	1,772,508			28
20	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,324,476	696,255	2,458,420	7,479,151	(113,260)	7,365,891	(419,449)	6,946,442		[29
2)	(Sum of fines o, 10 & 20)	7,527,70	070,233	2,730,720	1,717,131	(110,200)	7,505,071	(דבי,ינד)	0,770,774		1	4)

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

0027540

Report Period Beginning: 06/01/99 Ending:

V. COST CENTER EXPENSES (continued)

Facility Name & ID Number

			Cost Per Gen	eral Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	7
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			577,783	577,783	35,664	613,447	(62,930)	550,517			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			312	312	77,596	77,908	(312)	77,596			32
33	Real Estate Taxes			375,718	375,718		375,718	0	375,718			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			75,306	75,306		75,306	0	75,306			35
36	Other (specify):*							0				36
37	TOTAL Ownership			1,029,119	1,029,119	113,260	1,142,379	(63,242)	1,079,137			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportati	on						0				38
39	Ancillary Service Centers		511,895	6,949	518,844		518,844	0	518,844			39
40	Barber and Beauty Shops		11,278	2,588	13,866		13,866	0	13,866			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			107,056	107,056		107,056	0	107,056			42
43	Other (specify):* IV drugs		307,426		307,426		307,426	0	307,426			43
44	TOTAL Special Cost Centers		830,599	116,593	947,192		947,192		947,192			44
	GRAND TOTAL COST		1 - 4 < 0 - 1	2 <0.1.122	0.455.460		0.455.460	(100 (01)	0.0=4.==4			
45	(sum of lines 29, 37 & 44)	4,324,476	1,526,854	3,604,132	9,455,462	0	9,455,462	(482,691)	8,972,771			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Manorcare at Oak Lawn/95th

Print Preview

Page 4 05/31/00

24 Bad Debt

25 Fund Raising, Advertising and Promotional

Income Taxes and Illinois Personal

27 Nurse Aide Training for Non-Employees

30 SUBTOTAL (A): (Sum of lines 1-29)

29 Other-Attach Schedule Vending Inc. & Misc.

26 Property Replacement Tax

28 Yellow Page Advertising

0027540 Report Period Beginning:

24

25

26

27

28

29

30

06/01/99

Page 5 Ending: 05/31/00

TMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

(385,131) 21

(20,631) 20

(3,179) 21

(482,691)

VI.	ADJUSTMENT DETAIL A. The expenses indica				
	In column 2 below,	reference the line	on whic	h the particul	ar cost
	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1		\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(160)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,542)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(62,930)	30		9
10	Interest and Other Investment Income	(312)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,113)	21		13
14	Non-Care Related Interest				14
15					15
16	Personal Expenses (Including Transportation)	(2,417)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,275)	21		20
21	Owner or Key-Man Insurance				21
22					22
23	Malpractice Insurance for Individuals				23

	OHF USE ONLY	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTA			
37	TOTAL ADJUSTMENTS (A) and (B)	(482,691)		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3 4

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46	6)		\$		47

Print Other

Motions Delivers Educines Educ

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A Facility Name & ID Numb Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/99 Ending: 05/31/00 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61

Print Summar	SUMMARY OF PAGES 5, 5A, 6, 6	А, ОБ, ОС,	od, oe, or,	og, on Ar	וט עו								SUMMARY
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
A	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H		(to Sch V, col.7)
1	Dietary	0	0	0.12	0	0	0.0	0.2	0	0	0 11	0	0 1
2	Food Purchase	(160)	0	0	0	0	0	0	0	0	0	0	(160) 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(160)	0	0	0	0	0	0	0	0	0	0	(160) 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	F J	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	(-F 5)	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Program	0	0	0	0	0	0	0	0	0	0	0	0 16
	C. General Administration												
17		0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0 19
20	Fees, Subscriptions & Promotions	(20,631)	0	0	0	0	0	0	0	0	0	0	(20,631) 20
21		(393,062)	0	0	0	0	0	0	0	0	0	0	(393,062) 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	3	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	(2,417)	0	0	0	0	0	0	0	0	0	0	(2,417) 27
28	TOTAL General Administration	(416,110)	0	0	0	0	0	0	0	0	0	0	(416,110) 28
	TOTAL Operating Expense												
29	(sum of lines 8,16 & 28)	(416,270)	0	0	0	0	0	0	0	0	0	0	(416,270) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

- 1. Enter the information on pages 5 and 5A.
- 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

0027540 Report Period Beginning:

06/01/99 Ending:

Summary B 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Facility Name & ID Numb Manorcare at Oak Lawn/95th

Print Summary B

mmary													SUMMARY	r
		D. CEC	D. C.	D. CE										
	Capital Expense	PAGES	PAGE	PAGE	TOTALS									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, co	ol.7)
30	Depreciation	(62,930)	0	0	0	0	0	0	0	0	0	0	(62,930)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(312)	0	0	0	0	0	0	0	0	0	0	(312)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(63,242)	0	0	0	0	0	0	0	0	0	0	(63,242)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(479,512)	0	0	0	0	0	0	0	0	0	0	(479,512)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

- 1. Enter the information on pages 5 and 5A.
- 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The amounts in the column Q are linked to page 4.

HER THE PROCEDURES AT HIS BOTTOM OF THE WORKSHEET, B'THES, AGE SOT

FOLLOWER, HIS FORMAL AGE OF HIS SHAMAN FACES WILL NOT FIND PROPERLY.

Fields Now A HD Works, Museurer of De Lancestor

WHER LATED PARTIES.

(Sham Pip A Library Shaman Shama RELATED NURSING HOMES

Ownership No. Name Cay
100 Health Care & Retirement Corporation Tolodo, OH
64 America
ONE H.O. CONT REPORT) OTHER RELATED BUSINESS ENTITIES
Name City Type of Busine B. Are any costs included in this report which are a result of transactions with related organizations? This include management free, purchase of supplies, and so forth

X VES

NO If yes, costs incurred as a result of transactions with related organi the instructions for determining costs as specified for this form.

ſ			2	3 Cost Per General Ledge	r 4	- 5	Cost to Related Organization	6	7	8 Difference:		
Schedule V Line			lten	Amount	Г	Name of Related Organization	Percent	Operating Cos	t Adjustments for Related Organizat			
	Schedule v Line							Ownership Organization				
ſ	1	V	See	Home Office Allocation	5 526,000		HCR ManorCare, Inc	100.00%	5 526,000	5	-	
ſ	2	v	ě								,	
ſ	3	v	8								,	
ſ	4	v									٠	
ſ	5	v									,	

Sum_6

The desired ways with the same results of MASSANIST THEY WILL BETS THE FORMULAS.

1. Einer the information on pages 5 and 5.4.

2. Einer the information on pages 5 and 5.4.

3. For pages 6 the first of the information on pages 5 and 5.4.

3. For pages 6 the 6.4, Einer the information on pages 5 and 5.4.

4. For pages 6 the 6.4, Einer the information of the information of

Page 7

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Ho	urs Per Worl	k			
					Compensation	Week Dev	oted to this	Compens	ation Included	Schedule V.	,
					Received	Facility and	d % of Total	in Co	sts for this	Line &	
				Ownership	From Other	Work	Week	Repoi	rting Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

the name(s) PORTS.

Page 8

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/99 Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT C Show Pgs 8A thru 8D Show Pgs 8E thru 8I Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES X

NO

Street Address
City / State / Zip Code

333 N. Summit St.
Toledo, OH 43604-2617

Name of Related Organizatio HCR ManorCare, Inc.

B. Show the allocation of costs below. If necessary, please attach worksheets.

Phone Number (419) 252-5500 Fax Number (419) 254-5495

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost	#########	357 Nurs.Fac.		\$ 221,496	448,404		1
2	5	Utilities	Accumulated Cost	#########	357 Nurs.Fac.	4,614,666		448,404	20,655	2
3	10	Nursing	Accumulated Cost	#########	357 Nurs.Fac.	6,247,503	4,177,723	448,404	27,963	3
4	17	General & Administrative	Accumulated Cost	#########	357 Nurs.Fac.	80,443,795	26,746,978	448,404	360,055	4
5	22	Employee Benefits	Accumulated Cost	#########	357 Nurs.Fac.	520,233		448,404	2,328	5
6		Depreciation	Accumulated Cost	#########	357 Nurs.Fac.	7,968,019		448,404	35,664	6
7	32	Interest	Direct Cost	1	1	77,596		1	77,596	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21						·			-	21
22						·				22
23										23
24										24
25	TOTALS				9	\$ 100,260,290	\$ 31,146,197		\$ 526,000	25

0027540

Report Period Beginning:

06/01/99 Ending:

05/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
											Reporting	
					Monthly				Maturity	Interest	Period	
	Name of Lender	Relat	ted**	Purpose of Loan	Payment	Date of	Amou	nt of Note	Date	Rate	Interest	
		YES	NO		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X	Facility			\$ 2,340,310	\$ 2,340,310			\$ 77,596	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 2,340,310	\$ 2,340,310			\$ 77,596	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related	d					\$ 	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,340,310	\$ 2,340,310			\$ 77,596	15

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10

Facility Name & ID Numbe Manorcare at Oak Lawn/95th

0027540 Report Period Beginning:

06/01/99 Ending:

05/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.			\$	409,602	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers	more	than one year, detail below.)	\$	390,812	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(18,790)) 3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines be	elow.)	\$	393,591	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general (Describe appeal cost below. Attach copies of invoices to support the cost and a copy	-	=		917	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate to	ax a	opeal board's decision.)	\$		(
TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate to 7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	ax a _l	opeal board's decision.)	\$ \$	375,718	7
	ax a _l	opeal board's decision.)	\$	375,718	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6 Real Estate Tax History: Real Estate Tax Bill for Calendar Year: 1995 337,261 8	ax a	ppeal board's decision.) FOR OHF USE ONLY	\$	375,718	_
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6 Real Estate Tax History:	13		\$ \$ R 1999		7
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6 Real Estate Tax History: Real Estate Tax Bill for Calendar Year: 1995 337,261 8 1996 383,041 9		FOR OHF USE ONLY FROM R. E. TAX STATEMENT FOR			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6 Real Estate Tax History: Real Estate Tax Bill for Calendar Year: 1995 337,261 8 1996 383,041 9 1997 390,097 10 1998 390,574 11	13	FOR OHF USE ONLY FROM R. E. TAX STATEMENT FOR		\$	7

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

	ity Name & ID Numb(Manorca) UILDING AND GENERAL INF			STATE OF ILLIN # 0027540	OIS Report Period Beginning:	06/01/99 Ending:	Page 11 05/31/00
A.	Square Feet: 38,549	B. General Construction Typ	pe: Exterior	Masonary	Frame Steel	Number of Stories	1
C.	Does the Operating Entity? (Facilities checking (a) or (b) m	X (a) Own the Facility oust complete Schedule XI. Those c		n a Related Organiz nplete Schedule XI (<u> </u>	(c) Rent from Completely U Organization. ructions.)	J nrelated
D.	Does the Operating Entity? (Facilities checking (a) or (b) m	X (a) Own the Equipment		ipment from a Rela		(c) Rent equipment from C Unrelated Organization instructions.)	
Е.	(such as, but not limited to, apa	owned by this operating entity or re ortments, assisted living facilities, d ess, square footage, and number of	lay training facilitie	s, day care, indepen	dent living facilities, nurse a		
F.	Does this cost report reflect any If so, please complete the follow	y organization or pre-operating cosving:	sts which are being	amortized?	X YES	NO	
1.	. Total Amount Incurred:			2. Number of Year	s Over Which it is Being A	mortized:	
3.	. Current Period Amortization:			_4. Dates Incurred:			
		Nature of Costs: (Attach a complete schedule	detailing the total a	mount of organizati	on and pre-operating costs)	
XI. C	OWNERSHIP COSTS:	1	2	3	4		
	A. Land.	Use 1 2	Square Feet	Year Acquired	Cost 820,000	1 2	
		3 TOTALS			\$ 820,000	3	

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS # 0027540

0027540 Report Period Beginning:

06/01/99 Ending: Page 12 05/31/00

Facility Name & ID Number Manorcare at Oak Lawn/95th XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Beds		1	uing Depreciation-including Fixed Ed	2	3	4	5	6	7	8	9	\top
4 100 1981 1962 \$ 313,600 \$ 97,526 \$ \$ 97,526 \$ \$ \$ \$ 1,079,037 4			FOR OHF USE ONLY	Year	Year		Current Book	Life			Accumulated	
S 75 1981 1969 658,575		Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
6 10 1987 448,818 6 6 7 10 1999 1,235,114 7 PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 9 Current Year Depreciation 1986 7,924 1 10 1987 327,830 11 11 12 1988 251,787 11 12 1988 251,787 11 13 14 1990 20,876 11 13 15 1990 20,876 11 15 16 1991 65,304 15 16 1992 238,047 16 17 1993 325,229 1 17 18 1994 258,010 1 18 19 1995 481,391 1 199 20 BATHROOM REMODEL/PLUMBING 1995 481,391 199 21 RESIDENT ROOM REMODEL 1996 23,368 1 199 22 ROOF SYSTEM 1996 772 1 22 23 WALLVINYL 1996 772 1 22 24 CAPITALIZED LABOR 1996 141,970 1 22 25 CARPET 1996 7,722 1 23 24 CAPITALIZED LABOR 1996 7,722 1 23 24 CAPITALIZED LABOR 1996 7,722 1 23 25 CARPET 1996 2,3,68 1 21 26 ELECTRICAL/LIGHTING 1996 7,722 1 23 27 CARPET 1996 2,572 1 24 28 CARPET 1996 2,572 1 25 29 INSTALL POWER PANEL 1996 3,648 1 27 30 INSTALL POWER PANEL 1996 3,562 2 29 31 ROOFING 1996 3,562 2 29 32 INSTALL POWER PANEL 1996 3,476 31 33 INSTALL POWER PANEL 1996 3,459 31 34 INSTALL POWER PANEL 1996 3,572 31 35 REMODEL ENTRANCE 1996 4,359 35 36 REMODEL ENTRANCE 1996 4,359 35 36 REMODEL ENTRANCE 1996 4,359 35 36 REMODEL ENTRANCE 1996 4,359 35 37 REMODEL ENTRANCE 1996 4,359 35 38 REMODEL ENTRANCE 1996 4,359 35	4	100		1981	1962	\$ 313,600	\$ 97,526		\$ 97,526	\$	\$ 1,079,037	4
To To To To To To To To	5	75		1981	1969	658,575						5
R	6	10			1987	448,818						6
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 9 Current Year Depreciation 10 1986 7,924 264,037 1,221,299 9 10 1987 327,830 110 11 1988 251,787 111 13 1989 92,511 111 14 1990 20,876 113 15 1991 65,304 115 16 1992 238,047 116 17 1993 325,229 117 18 1991 45,304 115 19 1991 45,304 115 19 1991 45,304 115 19 1991 45,304 115 19 1991 10,000 REMODEL/PLUMBING 1994 258,010 118 19 19 19 19 19 19 19 19 19 19 19 19 19 1	7	10			1999	1,235,114						7
9 Current Year Depreciation 1986 7,924 264,037 264,037 1,221,299 9 10 11 11 1987 327,830	8											8
10		PLEASE	E REMOVE TEXT FROM COLUM	NS 2 OR 3			<u>'</u>					
11	9	Current Ye	ar Depreciation				264,037		264,037		1,221,299	-
12	10											-
13												
14												
15												
16												
17												
18	_					238,047						
19												
20 BATHROOM REMODEL/PLUMBING 1996 47,996 20 21 RESIDENT ROOM REMODEL 1996 23,368 21 22 ROOF SYSTEM 1996 141,970 22 23 WALLVINYL 1996 772 24 CAPITALIZED LABOR 1996 7,272 24 25 CARPET 1996 2,572 25 25 26 ELECTRICAL/LIGHTING 1996 4,108 26 27 TILE/FLOORING 1996 5,648 27 71LE/FLOORING 1996 5,648 27 28 CABINETS/COUNTERTOPS 1996 3,562 28 28 29 INSTALL POWER PANEL 1996 4,915 29 10 10 10 10 10 10 10 1												
21 RESIDENT ROOM REMODEL 1996 23,368 21 22 ROOF SYSTEM 1996 141,970 22 23 WALVINYL 1996 772 23 24 CAPITALIZED LABOR 1996 7,272 24 24 25 CARPET 1996 2,572 25 25 26 ELECTRICAL/LIGHTING 1996 4,108 26 27 TILE/FLOORING 1996 5,648 27 28 CABITES/COUNTERTOPS 1996 3,562 28 27 28 CABITES/COUNTERTOPS 1996 4,915 29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 2,550 33 34 INSTALL FENCE 1996 4,359 35 35 36 35 36 36 35 35		D + TITL 0 0										
22 ROOF SYSTEM 1996 141,970 22 23 WALLVINYL 1996 772 23 24 CAPITALIZED LABOR 1996 7,272 24 25 CARPET 1996 2,572 25 26 ELECTRICAL/LIGHTING 1996 4,108 26 27 TILE/FLOORING 1996 5,648 27 28 CABINETS/COUNTERTOPS 1996 3,562 28 29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35	_											
23 WALLVINYL 1996 772 23 24 CAPITALIZED LABOR 1996 7,272 24 25 CARPET 1996 2,572 25 26 ELECTRICAL/LIGHTING 1996 4,108 26 27 TILE/FLOORING 1996 5,648 27 28 CABINETS/COUNTERTOPS 1996 3,562 28 29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35												
24 CAPITALIZED LABOR 1996 7,272 24 25 CARPET 1996 2,572 25 26 ELECTRICAL/LIGHTING 1996 4,108 26 27 TILE/FLOORING 1996 5,648 27 28 CABINETS/COUNTERTOPS 1996 3,562 28 29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35												
25 CARPET 1996 2,572 25 26 ELECTRICAL/LIGHTING 1996 4,108 26 27 TILE/FLOORING 1996 5,648 27 28 CABINETS/COUNTERTOPS 1996 3,562 28 29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35												
26 ELECTRICAL/LIGHTING 1996 4,108 26 27 TILE/FLOORING 1996 5,648 27 28 CABINETS/COUNTERTOPS 1996 3,562 28 29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35			ZED LABUR									
27 TILE/FLOORING 1996 5,648 27 28 CABINETS/COUNTERTOPS 1996 3,562 28 29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35			CAL/LICUTING									
28 CABINETS/COUNTERTOPS 1996 3,562 28 29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35												
29 INSTALL POWER PANEL 1996 4,915 29 30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35												
30 INSTALL HVAC SYSTEM 1996 30,476 30 31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35												
31 ROOFING 1996 3,813 31 32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35												
32 LIGHTING/ELECTRICAL/WIRING 1996 12,563 32 33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35			TVAC STSTEM									
33 INSTALL FENCE 1996 2,550 33 34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35			/ELECTRICAL/WIRING									
34 INSTALL NEW DOORS 1996 4,359 34 35 REMODEL ENTRANCE 1996 4,800 35												
35 REMODEL ENTRANCE 1996 4,800 35												
									1			
				2 OR 3			\$ 361,563		\$ 361,563	S	\$ 2,300,336	

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Print Page 12A

STATE OF ILLINOIS

0027540

Report Period Beginning:

Page 12A 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Numbe Manorcare at Oak Lawn/95th

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar,

	1 D. Du	laing Depreciation-Including Fixed I	2	3	15.) Kounu an nui	5	6	1 7	8	9	$\neg \neg$
	1	FOR OHF USE ONLY	Year	Year	7	Current Book	Life	Straight Line	0	Accumulated	
	Beds*	FOR OHF USE ONE I		Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	Deus		Acquireu	Constructed	Cost	Pepreciation	m rears	Pepreciation	Aujustinents	© Depreciation	4
5					3	3		Ф	Ф	J	5
6											6
7											7
8											8
-	PLEAS	SEREMOVETEXT FROM COLUM	INS 2 OP 3								_
9		L STORAGE AREA	1113 2 OK 3	1996	6,323			I	ı		9
	DOOR AL			1996	26,749						10
		TORAGE TANK		1996	4,657						11
	AWNING			1996	1,948						12
		FLAGPOLE		1996	3,034						13
	LANDSCA			1996	5,840						14
	LIGHTIN			1997	10,958						15
	CARPETI			1997	8,187						16
		VERINGS		1997	2,256						17
	HVAC	12111.135		1997	11,443						18
		WATER HEATER		1997	17,300						19
-		ARM SYSTEM		1997	8,232						20
		E ENTRANCE		1997	5,261						21
22	DOORS &	FRAMES		1997	3,858						22
23	DECORA'	TING/FLOORING/COUNTERTOPS		1997	11,097						23
24	ROOFING	T		1997	1,950						24
25	ELECTRI	CAL		1997	1,683						25
26	RESURFA	CING & STRIPING		1997	17,574						26
27	OUTDOO	R LIGHTING		1997	11,047						27
28	RETIREN	IENTS		1997	(322,315)						28
29	RETIREN	IENTS		1997	(95,952)						29
30	WALLCO	VERINGS		1997	982						30
	CARPET			1997	14,571						31
_		CAL/PHONE WIRING		1997	3,142						32
	PLUMBIN			1997	11,684						33
	HVAC W			1997	11,723						34
35	CABINET	S		1997	9,040						35
36	PLEASE	REMOVE TEXT FROM COLUMN	S 2 OR 3		\$ #VALUE!	\$		\$	\$	\$	36

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

Print Page 12B

STATE OF ILLINOIS

0027540

Report Period Beginning:

Page 12B 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Numbe Manorcare at Oak Lawn/95th

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	nding Depreciation-Including Fixed F	2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4			- 1		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		SE REMOVE TEXT FROM COLUM									
		UCTION - RENOVATE NURSES STAT	ION	1997	7,882						9
		ALL SYSTEM		1997	16,897						10
		NEW DOORS		1997	14,939						11
	NEW BOI			1997	1,614						12
		Y PLAN ALLOC.		1997	2,759						13
		ACING & STRIPING PARKING LOT		1997	2,484						14
	ROOF W			1997	475						15
		VINDOWS		1998	14,393						16
		NG/FLOORING		1998	9,918						17
	PLUMBIN			1998	7,109						18
		ALL SYSTEM		1998	21,369						19
		CAL/LIGHTING		1998	6,712						20
	HVAC W			1998	2,896						21
		OVERINGS/DECORATING		1998	11,327						22
		L CONTRACTOR FEES		1998	29,348						23
		SIONAL FEES		1998	5,381						24
	FINISH/S			1998	5,000						25
_		ATE OVERHEAD		1998	1,651						26
	STORAG			1998	1,200						27
_	HANDRA			1998	500						28
		G/WALLCOVERING		1998	11,749						29
	PLUMBIN			1998	19,867						30
	ELECTRI			1998	120,126						31
	DEVELO			1998	5,573						32
		NG/CEILING		1998	1,005						33
	LIGHT F	IXTURE		1998	14,635						34
	HVAC			1998	4,664						35
36	PLEASE	REMOVE TEXT FROM COLUMN	S 2 OR 3		\$ #VALUE!	\$		\$	\$	\$	36

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Print Page 12C

Page 12C

| Facility Name & ID Numbe Manorcare at Oak Lawn/95th | XI. OWNERSHIP COSTS (continued)

0027540

Report Period Beginning:

06/01/99 Ending: 05/31/00

1	FOR OHF USE ONLY	Year	3 Year	4	5 Current Book	6 Life	7 Straight Line	8	9 Accumulated	
Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
				3	3		3	ð	3	-
										_
										+
										+
PLEA	SE REMOVE TEXT FROM COLUM	ANS 2 OR 3								_
	WINDOW		1998	7,859	T		T T	I		T
SIGN			1998	11,862						+
ROOFIN	NG		1998	9,497						\dashv
CARPEN			1998	23,573						\dashv
MILLW			1998	18,069						=
FINISH	STUDS		1998	72,611						_
PAVING			1998	20,595						_
SITE/DE	EMONLITION		1998	66,375						_
GAZEBO	0		1998	1,498						_
LANDSO	CAPING		1998	16,040						_
SITE/DE	EMONLITION		1998	4,000						_
)				·						_
FLOOR	ING/CEILING		1999	570						_
CARPEN	NTRY		1999	8,583						_
FINISH	STUDS		1999	823						_
PAINTI	NG/WALLCOVERING		1999	1,050						
PAINTI	NG/WALLCOVERING		1999	11,397						
ELECTE			1999	7,244						
	ING/TILE/CARPET		1999	54,402						
	ATIONS/ARTWORK		1999	1,131						
HVAC			1999	30,518						
	/WINDOWS		1999	8,068						
	EXTERIOR OF BUILDING		1999	10,408						
EXIT SI			1999	1,296						
DRAPES			1999	1,679						
	GE SHED		1999	2,760						
BUILDI	NG IMPROVEMENTS		1999	42,132						_
PLEASI	E REMOVE TEXT FROM COLUMN	IS 2 OR 3		s #VALUE!	\$		s	\$	\$	

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

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STATE OF ILLINOIS

0027540

Report Period Beginning:

Page 12D 06/01/99 Ending: 05/31/00

Facility Name & ID Numbe Manorcare at Oak Lawn/95th XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar,

	1	liding Depreciation-Including Fixed E	2	3	13.) Kouna an nui 1	5	6	7	8	9	\neg
	1	FOR OHF USE ONLY	Year	Year	7	Current Book	Life	Straight Line	0	Accumulated	
	Dada*	FOR OHF USE ONL!			Cost			Depreciation	A dinatananta		
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	\perp
4					3	3		3	\$	\$	4
5											5
6											6
7											7
8											8
		E REMOVE TEXT FROM COLUM	NS 2 OR 3	1000	15.074						
	LANDSCA			1999	17,961						9
		G LOT REPAIR		1999	7,525						10
		G/WALLCOVERING/CARPET		2000	42,709						11
		VINDOWS		2000	3,721						12
	CARPEN			2000	350						13
	GUTTER			2000	620						14
	RETIREN	MENTS		2000	(290,221)						15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE	REMOVE TEXT FROM COLUMNS	S 2 OR 3		\$ #VALUE!	s		\$	s	s	36
30	LEASE	REMOVE TEXT FROM COLUMN	JLONJ	L	ψ #YALUE:	9		Ψ	Ψ	Ψ	30

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Oak Lawn/95th

0027540

Report Period Beginning:

06/01/99 Ending:

05/31/00

2

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1	Current	Book	Straight Line	4	Componen	Accumulated	
	Equipment	Cost	Deprecia	ation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
37	Purchased in Prior Years	\$ 1,371,654	\$	150,869	\$ 150,869	\$		\$ 610,966	37
38	Current Year Purchases	73,919							38
39	Fully Depreciated Assets	(317,855)							39
40	Home Office Equity			•	35,664	35,664			40
41	TOTALS	\$ 1,127,718	\$	150,869	\$ 186,533	\$ 35,664		\$ 610,966	41

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Bo	ok	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation	on 5	Depreciation 6	Adjustments	Years 8	Depreciation	9
42	Resident	1995 Goshen GCH	1995	\$ 12,107	\$	2,421	\$ 2,421	\$		\$ 11,899	42
43		Paratransit									43
44											44
45											45
46	TOTALS			\$ 12,107	\$ 2	2,421	\$ 2,421	\$		\$ 11,899	46

E. Summary of Care-Related Assets

		Reference	Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 514,853	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 550,517	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 35,664	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,923,201	51

1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1		2	Current Boo	k	Accumulated	
	Description & Year Acquired		Cost	Depreciation	3	Depreciation 4	
52	Set-up Building	\$	1,573,243	\$ 62,9	30	\$ 1,169,444	52
53							53
54							54
55							55
56							56
57	TOTALS	\$	1,573,243	\$ 62,9	30	\$ 1,169,444	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

- * Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.
- ** This must agree with Schedule V line 30, column 8.

				_	STATE OF ILLIN						Page 14
Facility Name	& ID Number	Manorcare at Oa	k Lawn/95t	<u>:h</u>	# 0027540	Rej	port Perioc	l Beginning:	06/01/99	Ending:	05/31/00
1. Name 2. Does t	ng and Fixed Equ of Party Holding	y real estate taxes	ŕ	n to rental amount sho		olumn 4?]NO					
	1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Year Renewal Opt					
Original								10. Effective		U	reement:
3 Building:				<u> </u>			3	Beginning			
4 Additions	8						5	Ending			
5							6	11. Rent to be	a naid in futu	re veers und	or the cur
7 TOTAL				<u>s</u>			7	rental agi	-	ire years und	of the cur
This a by the		lated by dividing t	the total am	luded on page 4, line 3 ount to be amortized Terms:	*			Fiscal Year 12 13 14	/2001	Annual F S S S	kent
15. Is M	ovable equipment	Cransportation and trental included i ovable equipm	n building r	nipment. (See instruction tental? Description:	YES 02 Concentrators,]NO Wheelchairs, G dule detailing t	Gerichairs, The breakdo	Elect. Beds, etc. own of movable e	quipment)		
C. Vehicl	e Rental (See inst		-								
Us	se	2 Model Year and Make	N	3 Monthly Lease Payment	4 Rental Expens for this Period	i				o buy the bui	
17			\$		\$	17				ete details on	attached
18						18 19		schedule	•		
20						20		** This amo	ount plus any	amortizatio	n of lease
21 TOTAL			\$		\$	21		expense	must agree w	ith page 4, li	ne 34.

		S	TATE OF ILLI	NOIS			Page 15
Facility Name & ID Number Manorcare at Oak	Lawn/95th			# 0027540	Report Period Beginning:	06/01/99 Ending:	05/31/00
XIII. EXPENSES RELATING TO NURSE AIDE TRA	INING PROGRA	MS (See instruc	tions.)				
		•	ŕ				
A. TYPE OF TRAINING PROGRAM (If aides are	e trained in anoth	er facility progra	ım, attach a sche	edule listing the f	acility name, address and cost p	oer aide trained in t	hat facility.)
		<i>,</i> , ,		J			• /
1. HAVE YOU TRAINED AIDES	YES 2	. CLASSROC	M PORTION:		3. CLINICAL PO	RTION:	
DURING THIS REPORT							
PERIOD?	X NO	IN-HOUSE	PROGRAM		IN-HOUSE PRO	OGRAM	
		IN OTHER	EACH ITY		IN OTHER EAS	CH LTV	
If "yes", please complete the remainder		INOTHER	FACILITY		IN OTHER FAC		
of this schedule. If "no", provide an		COMMUNI	TY COLLEGE		HOURS PER A	IDE	
explanation as to why this training was		001/11/101/1	II COLLEGE		110011012111		
not necessary.		HOURS PE	R AIDE				
B. EXPENSES					C. CONTRACTUAL I	NCOME	
	ALLOCAT	TION OF COSTS	S (d)				
			· /		In the box below	v record the amoun	t of income ye
	1	2	3	4	facility received	training aides from	other faciliti
	F	acility			<u></u>		
	Drop-outs	Completed	Contract	Total	\$		
1 Community College Tuition	\$	\$	\$	\$			
2 Books and Supplies					D. NUMBER OF AIDE	CS TRAINED	
3 Classroom Wages (a)					COMPLETE	ED.	
4 Clinical Wages (b)					COMPLET		
5 In-House Trainer Wages (c) 6 Transportation					1. From this fac 2. From other fa		
7 Contractual Payments					DROP-OUT	()	
8 Nurse Aide Competency Tests					1. From this fac	- 10	
opinarse muc Competency rests	1	1	1	1	1. I I om this lac	**** J	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

2. From other facilities (f)

TOTAL TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

9 TOTALS

10 SUM OF line 9, col. 1 and 2

our ies.

05/31/00

0027540 Report Period Beginning:

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	`	1	,	2		3	4		5	6	7	8	
		Schedule V		Staf	f		Outside Practitioner		Supplies				
	Service	Line & Column	J	Inits of		Cost	(other th	an co	onsultant)	(Actual or)	Total Units	Total Cost	
		Reference	S	ervice			Units		Cost	Allocated)	(Column 2 + 4	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist	10a	6,340	hrs	\$	134,597		\$		\$ 2,543	6,340	\$ 137,140	1
	Licensed Speech and Language												
2	Development Therapist	10a	1,888	hrs		39,302	98		2,440	1,512	1,986	43,254	2
3	Licensed Recreational Therapist			hrs									3
4	Licensed Physical Therapist	10a	3,435	hrs		99,965	79		1,966	4,163	3,514	106,094	4
5	Physician Care			visits									5
6	Dental Care			visits									6
7	Work Related Program			hrs									7
8	Habilitation			hrs									8
				# of									
9	Pharmacy	39,2		prescrpts	3					511,895		511,895	9
	Psychological Services												
	(Evaluation and Diagnosis/												
10	Behavior Modification)			hrs									10
11	Academic Education			hrs									11
12	Exceptional Care Program												12
13	Other (specify): X-Ray & Lab	39,3							6,949			6,949	13
							· · · · · · · · · · · · · · · · · · ·						
14	TOTAL				\$	273,864	177	\$	11,355	\$ 520,113	11,840	\$ 805,332	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

0027540 As of 05/31/00 Report Period Beginning: 06/01/99 (last day of reporting year)

Ending:

XV. BALANCE SHEET - Unrestricted Operating Fund. As of This report must be completed even if financial statements are attached.

	This report must be completed to	1		2 After	
			Operating	Consolidation	*
	A. Current Assets				
1	Cash on Hand and in Banks	\$	69,459	\$	1
2	Cash-Patient Deposits				2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance (448,886))		1,887,095		3
4	Supply Inventory (priced at)		11,178		4
5	Short-Term Investments		2,285		5
6	Prepaid Insurance				6
7	Other Prepaid Expenses		4,813		7
8	Accounts Receivable (owners or related partie	es)			8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,974,830	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		820,000		13
14	Buildings, at Historical Cost		6,949,453		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		1,139,825		16
17	Accumulated Depreciation (book methods)		(4,092,645)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): CIP & Other Assets		39,112		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	4,855,745	\$	24
	moral Aggrega				
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	6,830,575	\$	25

		1	Operating		2 After
	C. Current Liabilities		sper aring		onsonuution
26	Accounts Payable	\$	28,388	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		190,550		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		27,532		31
32	Accrued Real Estate Taxes(Sch.IX-B)		361,281		32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Accrued Trade Payables & Liabilities		58,390		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	666,141	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation	<u> </u>			42
42	Other Long-Term Liabilities(specify):			1 42
43					43
44	TOTAL I TO A LINE				44
4.5	TOTAL Long-Term Liabilities	0		Φ.	145
45	(sum of lines 39 thru 44)	\$		\$	45
10	TOTAL LIABILITIES	a.	(((141	6	140
46	(sum of lines 38 and 45)	\$	666,141	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	6,164,434	\$	47
48	TOTAL LIABILITIES AND EQUIT (sum of lines 46 and 47)	Υ \$	6,830,575	s	48

*(See instructions.)

Page 18 Ending: 05/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

			1	
			Total	
1	Balance at Beginning of Year, as Previously Reported	\$	12,163,029	1
2	Restatements (describe):			2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	12,163,029	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		1,570,558	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	1,570,558	17
	B. Transfers (Itemize):			
18	Change in Interdivision		(7,569,153)	18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$	(7,569,153)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	6,164,434	24

^{*} This must agree with page 17, line 47.

Ending:

Report Period Beginning: XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	3		1	
	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	11,065,369	1
2	Discounts and Allowances for all Levels		(2,567,905)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	8,497,464	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy		1,919,936	6
7	Oxygen		26,929	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	1,946,865	8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop		4,172	12
13	Barber and Beauty Care		15,816	13
	Non-Patient Meals		160	14
15	Telephone, Television and Radio		5,542	15
16				16
17	Sale of Drugs		509,391	17
18	Sale of Supplies to Non-Patients		•	18
19	Laboratory		7,233	19
20	Radiology and X-Ray		468	20
21	Other Medical Services		8,608	21
22	Laundry		13,403	22
23	SUBTOTAL Other Operating Revenue (lines 9 thr	\$	564,793	23
	D. Non-Operating Revenue			
24	Contributions			24
	Interest and Other Investment Income**			25
26	SUBTOTAL Non-Operating Revenue (lines 24 and	\$		26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.	.)		27
28	Misc. \$1,787, Purchase Discounts \$1	Ĺ	1,788	28
	Late Charges		15,110	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	16,898	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29	\$	11,026,020	30

· IIG	revenue agamst expense.	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 1,201,874	31
32	Health Care	3,921,863	32
33	General Administration	2,355,414	33
	B. Capital Expense		
34	- · · F	1,029,119	34
	C. Ancillary Expense		
35		840,136	35
36	Provider Participation Fee	107,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,455,462	40
41	Income before Income Taxes (line 30 minus line 40)**	1,570,558	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus	\$ 1,570,558	43

*	This must	t agree with	page 4.	line 45.	column 4.

**	Does this agree with	taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Manorcare at Oak Lawn/95th XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

	(This schedule must cover the entire reporting period.)								
	T	# of Hrs.	# of Hrs.		Reporting Period		4		
		Actually	Paid and		Total Salaries,	u i	Average Hourly		
		Worked	Accrued		Wages		Wage		
1	Divertor of Nauring	5,299	5,825	S	158,634	S	27.23	1	
2	Director of Nursing Assistant Director of Nursing	349	384	Э		Þ	25.21	2	
	9			-	9,681			3	
3	Registered Nurses	28,026	30,811		597,299		19.39	-	
	Licensed Practical Nurses	42,674	46,914		777,899		16.58	4	
	Nurse Aides & Orderlies	115,802	127,308		1,082,564		8.50	5	
_	Nurse Aide Trainees							6	
	Licensed Therapist	11,192	12,308		301,180		24.47	7	
	Rehab/Therapy Aides	9,029	9,930		151,393		15.25	8	
9	Activity Director	9,260	10,173		91,385		8.98	9	
	Activity Assistants							10	
	Social Service Workers	7,671	8,365		130,945		15.65	11	
	Dietician							12	
13	Food Service Supervisor							13	
14	Head Cook							14	
15	Cook Helpers/Assistants	32,036	35,098		332,553		9.47	15	
16	Dishwashers				•			16	
17	Maintenance Workers	3,858	4,257		64,140		15.07	17	
18	Housekeepers	22,034	24,219		166,662		6.88	18	
19	Laundry	8,699	9,559		56,641		5.93	19	
	Administrator	2,080	2,080		70,574		33.93	20	
21	Assistant Administrator	1,439	1,439		34,557		24.01	21	
22	Other Administrative	,	,					22	
	Office Manager			1				23	
	Clerical	17,538	20,265	1	273,355		13.49	24	
25	Vocational Instruction	,	-,	1	-)			25	
	Academic Instruction			1				26	
	Medical Director			1				27	
	Qualified MR Prof. (QMRP)			1				28	
	Resident Services Coordinator	<u> </u> 		1				29	
	Habilitation Aides (DD Homes							30	
	Medical Records	2,116	2,327	1	25,014		10.75	31	
	Other Health Care(specify)	2,110	2,027	1	20,017		10.75	32	
	Other(specify)			1		_		33	
	(I V /	210 102	251 262		1 321 176 *		12.21		
54	TOTAL (lines 1 - 33)	319,102	351,262	\$	4,324,476 *	\$	12.31	34	

^{*} This total must agree with page 4, column 1, line 45.

Print Preview

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant Schedule V		
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	24,686	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	79,397	10a,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) H/R	One Time	249	21,5	46
47					47
48					48
49	TOTAL (lines 35 - 48)		s 104,332		49

C. CONTRACT NURSES

_		1	2	3	
		Number	Schedule V		
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	130	\$ 2,563	10,3	50
51	Licensed Practical Nurses	3,125	56,211	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,255	\$ 58,774		53

^{**} See instructions.